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NEW DIMENSIONS IN AGING

Research and Statistics Directorate

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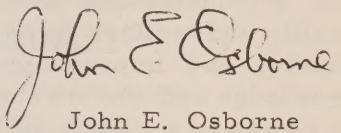
foreword

The development of facilities and programs to serve the aged is not new. Institutions such as homes for the aged and nursing homes have been built at an accelerated rate over the years. In local communities housing projects, clubs, homemaker services, meals-on-wheels programs, and other developments for older adults have increased. Programs for the aged and aging established by the Department of National Health and Welfare and provincial and municipal departments of health and welfare have shown continuing expansion and improvement. With advances in knowledge and the betterment of skills and techniques, such progress should not be surprising. But the future beckons us to try new and greater things.

With more people living to the later years, Canadians should become more concerned about the happiness and well-being of older adults — our mothers, our fathers, our relatives and friends. We must be more imaginative in developing the kinds of programs which will allow older people to remain in the community at large for as long as possible. We must be more ingenious in providing opportunities for older adults so that their lives may remain meaningful, have purpose, and bring happiness and fulfilment. The later years of life should be as rewarding in their own special way as the earlier stages were in theirs.

The purpose of this booklet is to describe some of the unusual programs that have been organized. It has been prepared by Miss Lola Wilson, the Consultant on Aging in the Research and Statistics Directorate, who has visited each of the programs described.

It is my hope that this publication will have wide circulation, and that it will stimulate more creative services to help the aged. Perhaps some of these will be organized and developed by older persons themselves.



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"belvedere" and "prospect house"

These two residences offer inexpensive housing for aged persons in Montreal (Westmount). Because such facilities as kitchens, bathrooms and sitting rooms are shared, rents are as low as $25 per month for a single person, $38 for a couple. Imagination has been shown in developing a type of living arrangement which allows residents an opportunity to continue to live independently in the community, while providing them with protective oversight.

"BELVEDERE" AND "PROSPECT HOUSE"

"Belvedere" and "Prospect House" are located in Montreal (Westmount). They are residences which allow older persons to live with a maximum of independence, privacy, and community integration at minimal rental costs. Both are owned and operated by the Family Service Association. While it is unusual, indeed rare, to find a family service agency providing living accommodation for elderly people, this is not the feature which commends the development; any agency or group could do the same. What is unique is the vision displayed in creating a type of living arrangement which serves those on very low incomes and permits them freedom to continue to remain independently within the community.

History of Development

In 1949 a generous bequest to the Family Service Association permitted the establishment of the first "Belvedere". In 1960, this residence was sold at a good profit and a new and larger "Belvedere" was opened adjoining the offices of the agency at 4515 St. Catherine Street West, Westmount. The two-storey building which was purchased for "Belvedere" was renovated and modified to suit the needs of older people. It houses 26 men and women. Since most rooms have connecting doors, a two-room suite can be adapted for couples. Single persons have one room. Tenants pay $25 per month for single, $45 per month for couple, accommodation.

"Prospect House" was started in 1961 by the Rotary Club of Westmount. Two old homes at No.1 Prospect Street were purchased and completely renovated to provide housing for 14 aged persons. The total cost of land, renovations and furnishings of $100,000 was borne in full by the Rotary Club. In 1963 the club donated the project to the Family Service Association. In this project rents are

$28 per month for a small single room, $35 for a larger single room, and $38 for a couple unit of two rooms.

Living Arrangements

Living arrangements in the two projects have common denominators. Every resident has a key to his own room to ensure privacy. In addition, he has a key to the front door so that he may come and go as he wishes. Only if a resident plans to be absent overnight is he required to notify the resident caretaker of his whereabouts. Meals are prepared in common kitchens (there are four in "Belvedere", two in "Prospect House"). Usually residents prepare meals, two by two, under a schedule agreed upon by the tenants. Each resident has a separate compartment for food storage in the large refrigerators. There are eight bathrooms in "Belvedere" and six in "Prospect House". Both have common lounges and laundries. Shared telephone facilities are provided at both projects.

Each project has a "caretaker-janitoress". She and her husband occupy an apartment in the project. The janitoress cleans the common rooms (kitchens, bathrooms, lounges, halls) and supervises the servicing of laundry and supplies; heavy laundry service is provided along with basic furniture, linens, towels, and curtains. The husband (employed full time in the community) attends to heating, garbage and snow removal.

Admission Requirements

Applicants for accommodation must be aged 60 or over. A recent medical report must be submitted before admission. An applicant is given a letter describing the activity required for the information of his doctor. Two references of sociability are requested. Lack of any relatives or of

a sponsor (to assist in planning or to arrange some other form of care in the event of illness) does not disqualify anyone. The maximum monthly income a single person may have is $150; a couple, $225. An Admissions Committee composed of four social workers reviews and approves the applications.

Characteristics of Residents

It is evident that living arrangements with some shared facilities can allow many older people to continue normal life in the community. There must, however, be certain elements of homogeneity and equality; and these must be taken into account in the selection of residents. In both projects there is a common background of education, employment, earnings, abilities and social stability — of major importance in group housing. None of the tenants have been affluent; all have managed all their lives on meagre incomes; all have worked hard all their lives. No one denies that disagreements and quarrels do occur, as is the case in any normal family; but as in a normal family the problems can be, and are, resolved.

The tenants want to live as participants in the community. Rarely are parties, movies, or entertainment of any kind "taken to" the residents. Instead, they use the community facilities. Parks, stores, banks, libraries, churches, Golden Age Clubs, public transportation — all these and more are easily accessible, and all are used by the residents.

Many of the residents have physical disabilities, or continuing disease conditions; yet they do not consider themselves seriously handicapped or unable to care for themselves. About one resident each year has had to leave because of severe illness. More often, a resident who is ill manages independently until perhaps the last few weeks of his life. The Victorian Order of Nurses visits to provide care

when required. Some residents have private doctors, some attend out-patient clinics regularly, and upon occasion a doctor from the United Red Feather Services is asked to visit a resident.

Role of Social Workers

Through a Board-Staff Old Age Committee for each residence, the tenants can express their wishes. Overall supervision of the projects is carried out by a social worker assigned this responsibility by the Family Service Association. Perhaps of more consequence, however, is that a social worker is assigned to each resident. For some with no relatives or close friends this is of paramount importance; the social worker becomes the resident's "family".

Group Housing is Economical

That group housing can be remarkably economical is evidenced by the fact that the operating costs of "Belvedere" are about $8,000 per year, of "Prospect House" just over $5,000, with both exempt from municipal taxation. The projects are self-supporting, exclusive of the salaries involved for the time of staff assigned by the association. Such living arrangements allow aged persons on low incomes to remain independent while at the same time protective oversight is provided. Full use is made of community resources. Older folk at "Belvedere" and "Prospect House" remain integrated in, not segregated from, the community.

Activities of Residents

Just how normal the life of the elderly residents is can be observed in their activities. A visitor to one of the residences just at the supper hour was told by a lady in her late 80's that she was sorry to appear rather rushed but she had to

hurry to get away to her square dancing group — she square dances three evenings each week at a different club on each occasion. Her companion in the kitchen, a lady in her late 70's, was equally hurried. She had to leave for a meeting at her church. One resident finally decided, at age 85, to give up a part-time job. At age 74 a grandmother cheerfully acknowledges receipt of a cheque from Air Canada for her work in posing for photographs. In the cosy lounges mending, handicrafts, and visiting are daily activities, with the television turned low "in case there is anything interesting". Each resident displays a pride in his residence and particularly in his own "home". While this may be just one room, it is truly home.

camp easter seal

Summer holiday camps can provide an adventure in living for disabled older adults. When the sponsoring agency truly believes in the benefits such a venture can have, others are converted — including the aged! You may be in your 90's, confined to a wheelchair, and never before have gone swimming; you may not even own a bathing suit. But you'll never be any younger, so why not try? Camp Easter Seal, on Manitou Lake in Saskatchewan, offered new experiences as well as a chance to renew some that campers thought were but fond memories.

CAMP EASTER SEAL

A holiday camp for disabled older persons was established as an experimental project in 1961 at Camp Easter Seal, Manitou Beach, Saskatchewan. One objective was to provide a "memorable holiday" for those attending by meeting their physical and social needs through recreation. Other objectives were to test the usefulness of a camping experience for older disabled persons, learn the problems associated with it, appraise the suitability of the facilities, determine the kind of program needed, and assess the possibility of involving young staff persons as "counsellors" for a camp of not just aged persons but disabled aged persons.

Camp Site

Camp Easter Seal is owned and operated by the Saskatchewan Council for Crippled Children and Adults. It was established to provide summer outings for handicapped and disabled children and adults. The site is four miles north-north-east of Watrous, a town located about 75 miles south-east of Saskatoon.

The camp is situated on a fairly steep hill rising from the shore of Manitou Lake. The area is heavily treed and a rural-like setting has been maintained. Because of sharp inclines, concrete ramps have been built to facilitate wheelchair movement. Sleeping accommodation is provided in cabins located in close proximity to two chalets which house the eating, recreation, infirmary and service facilities as well as executive staff quarters.

A patio between the two chalets furnishes an ideal place for teas and other social activities. Grassed and shaded play areas front on the chalets. A larger grassed area nearby is used for picnics and sports. Manitou Lake, which is heavily mineralized,

is used for boating. A fresh water swimming pool, heated to room temperature, is a special feature of the camp. The stone-walled chalets, the stone-work terraces, the lawns, the grassy and shaded play areas, the rustic cabins, the nearby lake, and the profusion of trees and shrubbery make for a very impressive holiday camp setting.

Selection of Campers

Three criteria were established for the selection of campers:

1. "Disability or disabilities must be manageable within the camp's limitations;
2. "Applicant must be in possession of his own volition or, in the case of its impairment, not likely to be a danger to himself or others;
3. "Final approval of applicants for camp shall be made by the Camp Admission Committee after careful review of their social history, health record, and other pertinent data."

It was decided that campers should be aged 45 or over. In actual fact, most campers were aged 60-70 years, but in the two camps held in 1961 there were several aged 71-80. In the first camp the oldest camper was 90; in the second, 91. Each camp served about 30 persons. All campers in the first camp came from institutional settings, but one camper in the second camp came from a nearby housing development for senior citizens. It should be noted that the first camp was for four days. Evaluation showed the stay was too short, but a period of 10 days or two weeks was considered too long. A seven-day camp seemed to be indicated and the second camp was established for this period. It proved to be "just right" and seven-day camps for future years were recommended.

Facilities Adequate

Facilities proved adequate; while there were some problems, none were insurmountable. Many of the campers were in wheelchairs. For these persons as well as for many others getting in and out of the swimming pool presented difficulties. Indeed, the majority of the campers required help for this. Subsequently, a newly designed pool was constructed which overcomes the problems. The somewhat rugged topography caused some concern for those planning the camp. It proved, however, to be a challenge welcomed by the campers. Some of the ramps are very steep, but the strong arms of youthful counsellors overcame any obstacles. There were no complaints about food! Outdoor living whetted what might otherwise have been indifferent appetites.

Programming

Two types of programming were tried: a regular scheduled program with croquet, boating, swimming, table tennis, horseshoes, dancing and other games and sports activities; and an elective program which allowed the camper to choose two specific areas in which he wished to participate — for example, crafts, sketching, air rifle shooting, singing Negro spirituals. But a program with a predetermined schedule of events which was so successful with disabled children was not readily accepted by the disabled older adults. Flexibility here, as in all such situations, was essential. Program changes had to be made whenever needed due to personal preference, fatigue, and the diversity of the campers. Activities developed spontaneously. The task of the program staff was to set up a wide range of activities allowing the campers to participate in what they wanted as they wished. Counsellors informed the campers of all that was available for them to do, encouraged them to make a choice and then, when necessary, helped them to participate. Active programs were emphasized rather than those which were too sedentary.

For a very few the change of scene was enough. Indeed, among the entire group the most frequent comment heard was the expression of delight in being outdoors among trees and hills. At first, there was "too much programming" in a prescribed pattern. Some campers were quite fatigued the first day and there were comments like: "They're going to kill us", "They're going at it too fast here. We should have older persons around 70 running things" and "These youngsters are going at it too hard." One camper who spoke in this vein two days later said: "I sure get a kick out of everything. I suppose if I had a choice I'd as soon just sit, but....." When it came time to go home, this same individual "reckoned the camp might have been a couple of days longer".

In the first camp there had been a tendency in the beginning to rush the campers into a heavy program. This can be attributed partly to the shortness of the camp period, partly to the lack of previous experience with a group of aged disabled persons. With time, the camp program staff and counsellors recognized the need for greater flexibility in the program while the campers meanwhile "gained momentum daily" — a happy situation for all concerned. Future campers were the beneficiaries of this initial learning experience in adjusting to program needs.

Staff

Staff for the camps consisted of three groups: the regular staff, including the camp director, secretary, program and counselling (staff) directors, area supervisors for sports, music, swimming and handicrafts, nurse, kitchen staff, laundress, and a caretaker-handyman; personnel on loan from the participating institutions, who provided any special physical care required by "their" residents; and the counsellors. The last named group was largely responsible for the success of the camps.

Counsellors were mainly university students or student teachers. Initially there had been some concern expressed about the ability of these young people to act as counsellors for a senior group. A pattern of respect and decorum was set at the opening, including the instructions that campers were to be addressed as "Mr., Mrs. or Miss", unless the camper asked to be called by his given name. But any feelings of restraint and undue formality quickly dissolved in an atmosphere of close friendship. Rather than resenting that young people encouraged them, took them to activities and even lived with them in the cabins (for a counsellor always had to be close by), the older people seemed to appreciate having young people take an interest in them.

Aside from the usual duties associated with the work of a camp counsellor, anyone undertaking such responsibilities in a camp for disabled older adults is expected to provide the kind of stimulation and companionship which will ensure the campers the fullest possible enjoyment from their camping experience. Establishing good rapport with the campers is of vital importance. Thus applicants for counsellor work must be carefully screened, especially in terms of temperament, before being accepted. Most of the counsellors had a personal interest in the work in which Camp Easter Seal is engaged. Such interest may have been due to the nature of the educational program being followed at university, or to a close relationship to disabled persons in their own families, among their friends, or in their working situation.

All the counsellors admitted they were somewhat fearful at first in working with the older adults; they did not know what to expect. With one or two exceptions, however, they performed splendidly. Rapport was quickly established, the counsellors were sensitive to the needs and apprehensions of the older people, and they experienced great satisfaction in their work.

Campers

And what of the campers themselves, those aged disabled individuals about whom some concern had been expressed that "A camp is no place for them"? They were stimulated to do things they had not done for years and never dreamed of doing again. When interest was expressed, it was important to follow through on it and the counsellors did. For example, swimming was perhaps the most popular activity. Some campers had never been swimming in their lives. When a lady in her 90's, in a wheelchair, expressed the desire to "try it", the fact she had no bathing suit proved no obstacle to the ingenious girl counsellors. As they said: "We just whipped up a suit out of bath towels and in she went." The truth of this cannot be denied for pictures were taken to prove it to "those back home"! That bathing suit got a lot of use by its owner during the remainder of camp. When the desire for a motorboat ride was expressed by one or two campers, a motorboat was rented and all but one camper signed up for a ride.

The games, handicrafts, singing, hayride, banquet (complete with toasts) and a dance — in all there was enthusiastic participation. A daily Camp Newspaper commenting upon the day's program and events yet to come was popular, indeed enjoyed by staff and campers alike. All this activity and involvement took place with no illness of any consequence during either camp. Typical of the nurse's reports concerning the individual campers was that on Mr. M.: "He looks 20 years younger now than the day we interviewed him."

The vital response of the disabled older persons to the camp experience could be repeated in stories about each one. Suffice it is to describe Mr. H., badly crippled by arthritis and Parkinson's disease. Upon arrival at camp he did not think he could do anything. Left to his own devices, he would

have spent most of each day lying and dozing on his bed. The first day he did just that. But what Mr. H. needed was someone who recognized and respected the fact that he could still maintain a measure of independence, and to reassure him that he could still function actively within the limitations of his disabilities. His counsellor provided the reassurance, while stimulation to try to do things was probably a mixture of help from the counsellor and watching his peers become involved. By the third day Mr. H. was playing horseshoes, swimming, and almost constantly on the move. On the last night in camp, he could not wait for the dance to start and boasted proudly that he did not miss a dance. As the camp came to an end, Mr. H. was having the time of his life. The only time his face clouded over was when he got into the car to leave Camp Easter Seal for the institution where he lives.

Conclusions Reached Through Evaluation

Upon evaluation, certain features stand out as important in a camping program for disabled older adults. One was the submission with the application of the camper's social and health history. The information was provided by the institution, or by the doctor for those living independently in the community. It proved invaluable in preparing the staff and counsellors to meet special needs of campers and deal with problems with a minimum of disturbance. It should be noted, however, that while these reports established an awareness of behaviour patterns, emotional stability, and the like, care was taken that campers were not "pre-judged". The wisdom of this was soon demonstrated. In a few days in a new setting, with new and interesting people around, with opportunities to do new and exciting things, personality changes observed in some of the campers were often quite remarkable.

At the end of each camp session a "camper report" was prepared for each person. It stated the

activities engaged in, level of achievement reached, behaviour patterns observed, friendships established, and other relevant information. Thus when the camper returned the following year, there was a guide against which to predict his potential and measure his success. In addition, a better assignment of campers to cabins with people with whom friendships had been started the previous year was possible. Good records are essential, particularly where staff turnover is high as in a camp program (50 per cent or more in the program being described).

An Adventure in Living

The success of the camp experience cannot be doubted. It was attested to by the staff, the institutions co-operating in the venture, and most important of all by the campers themselves. The recommendation that camps be a continuing part of the program at Camp Easter Seal was accepted and additional camps were held in 1962 and 1963. That they have not been held since is the result of shortage of funds, and not because the need no longer exists. It is hoped that Camp Easter Seal will serve older disabled adults again very soon. The vision displayed in organizing the experimental project should not be lost. Other communities, where suitable facilities are available, should consider providing this kind of adventure in living for their disabled aged.

care services

Accepting the fact that both the Department of Health and the Department of Welfare have responsibilities in serving the aged and adult infirm which cannot be separated but rather must be shared, the Government of Manitoba, in 1963, established "Care Services". Sharing of responsibilities, it was believed, would result in the maximum co-operation, co-ordination and integration in achieving the goals of the program. It was agreed that the basic services and primary professional skills needed to implement the plan were to be found in health and welfare. "Care Services" represent an imaginative administrative approach in serving the aged and adult infirm.

CARE SERVICES

Care Services in Manitoba represent an imaginative administrative approach in serving the aged and adult infirm. The programs which make up the components of Care Services do not differ from those found in other communities including nursing homes, homes for the aged, organized home care, foster homes (private family living), and other ancillary community services. It is the dynamic concept of Care Services embracing the inseparability of health and welfare which marks its uniqueness. Here in a venture of shared responsibility by a provincial department of health and a provincial department of welfare is a practical demonstration designed to meet the social needs of older people through joint effort which, despite difficulties, is slowly learning how to achieve a smooth working arrangement. Striving for oneness was inherent in the plan from the outset because it was

(a) recognized that the basic services and primary professional skills needed to implement the plan were to be found in both health and welfare;

(b) based on a belief that shared responsibility could assure maximum co-operation, co-ordination and integration in achieving the goals of the program.

Responsibility of Program

The Government of Manitoba established the structure for a Care Services Organization in January 1963. It became operational in June 1963 under the name "Care Services". Its responsibility, tersely stated, is to develop services for the aged and adult infirm, in need of care, but not requiring hospital care. The statement is deceptively simple. The Care Services project in fact is charged with

developing "an organization, policies, and procedures, in which the staff, skills and resources of each (Departments of Health and Welfare), can be brought to bear in an orderly manner on the problems of caring for people in the various care categories below the Hospital Services (Manitoba Hospital Services Plan)".

Organizational Structure

The rural areas of Manitoba have been divided into regional districts. The provincial welfare director and the medical officer of health in each region assume equal responsibility for the development of care services. But the problems of organizing in Metropolitan Winnipeg were compounded by the existence of 19 municipalities within the area. To overcome this difficulty, a central office was established, staffed from both the participating provincial government departments, and charged with the task of providing and developing care services below the level of hospital care to serve residents of the entire metropolitan area. The central office was given further responsibilities including: the provision of overall provincial direction and supervision in respect to licensing and standards for homes for the aged, nursing homes and similar institutions providing care below the level of hospital care; the reviewing of rates charged and participation in programming in institutions; the development of alternative forms of care; and the planning of new care facilities including institutions.

Roles of Directors

There are two main sections in Care Services — one health, one welfare. Each has its own director who is responsible for the legislative program of his own department within Metropolitan Winnipeg, and for co-ordinating the provision of services and the development of programs within the area with the other director. Thus the welfare director is

responsible for the administration of The Social Allowances Act to provide necessary financial assistance to those being served by Care Services. The health director, on the other hand, assumes responsibility for issuing licences in respect to institutions and homes as well as providing supervision of homes and of medical services, whether inside or outside institutional care, for persons using Care Services. Jointly the directors are responsible for providing the on-going daily health-welfare services, for developing a range of programs below the level of hospital care, for establishing and improving standards by which to assess the adequacy of programs both in institutions and ancillary community services accepting responsibility for persons on Care Services, and for the development of activity programs in homes and institutions within Metropolitan Winnipeg.

Means for Liaison

For the province, the directors and staff act as resource people to the regional welfare directors, medical officers of health and their staffs. Such an arrangement allows for the direct association between Care Services and the regions to ensure similar standards, facilities, and services throughout the province. Further, there is a direct liaison between the directors of Care Services and the Manitoba Hospital Services Commission in respect to the planning of programs, both institutional and non-institutional, to better serve those requiring long-term care, but not in need of care in a general hospital. Finally, there is a close association and working arrangement between the directors of Care Services and the Director of Elderly Persons' Housing in the planning and administration of new care facilities for the aged.

Individual Needs Assessed

The case conference method is used to evaluate the health, social needs, and resources of each individual referred to Care Services. Conferences are attended by the appropriate personnel — physicians, nurses, social workers, consultants, resource persons, and secretary. A preferred plan of care is designed for each individual along with an alternative plan or plans. Alternative plans are for use when preferred resources are not immediately available or when the reaction by the individual being served is not favourable to the preferred plan. Care may be given in some institutional facility (for example, a nursing home, home for the aged), in the individual's own home, in the home of a relative, or in a foster home. When a person is placed other than in institutional care, supportive assistance is provided as required, for example, organized home care, homemaker service, meals-on-wheels, counselling, financial, and even home-care equipment. There is a continuing assessment of individual needs and adjustments are made as necessary.

Education and Research

Care Services have undertaken noteworthy developments in education. Prior to 1967, a unit for first year students of the University of Manitoba's School of Social Work was located in the offices of Care Services. Under supervision, the students carried a caseload for the program. Thus an important liaison with the School of Social Work began. While a problem of space to accommodate the students necessitated their movement from Care Services to another part of the Department of Welfare's program, a more significant feature in the change was the conclusion reached, as a result of experience, that Care Services could be better utilized in the placement of second year students. Efforts to effect this new arrangement are now being undertaken, since it is believed that

intensive teamwork experience and the opportunity to learn to work with older people strengthens the student's program.

In-service training programs have been organized. For example, in 1967 an institute for nurses working in homes for the aged was held; a training program for auxiliary nursing personnel has been conducted.

Research has an important role in Care Services. A program including arts, crafts and activities for diversion has been introduced into several homes for the aged and the results are being studied. In a selected non-proprietary home a project involving such services as dental, psychiatric, physiotherapy and occupational therapy has been started, coupled with an in-service educational program. The results of this kind of development will help in determining the pattern of care for implementation in other institutions. In an attempt to discover ways whereby patients discharged from mental hospitals can be re-established in the community, several projects have been organized in co-operation with the Selkirk Mental Hospital.

In 1967, through the Welfare Grants Program of the Department of National Health and Welfare, Care Services, in conjunction with the Department of Sociology and Anthropology of the University of Winnipeg, began a survey of the Aged and Adult Infirm Foster Family Care Program. Its objectives are: to assess the effectiveness of the existing foster home program; to establish criteria to assist in the selection of individuals who would benefit from a foster family environment; to recruit and select suitable foster families and to improve placement decisions.

Through the educational and research projects being undertaken, as well as through daily services

offered, Care Services hope to "further knowledge of the geriatric field, broaden and improve the scope for the care of elderly and infirm citizens and ensure full utilization of hospital, medical and paramedical services, along with the resources of the community". Emerging more clearly is a delineation of the type of care which should be provided by hospitals, auxiliary institutions, and ancillary community services.

Health and Welfare Personnel Learning to Work Together

Time will no doubt bring about modifications, perhaps even very fundamental changes, in the structure of Care Services. But regardless of the future design, the Care Services program has provided an opportunity for personnel in health and welfare to learn to work together in an inter-disciplinary approach. The staff members of Care Services do not just talk about co-ordination, co-operation and integration, they are learning how to achieve these.

earlham care program

The small town of Earlham, Iowa has developed a total community program to serve the aged and long-term ill which allows them to remain in the community outside institutional care. Through imaginative leadership, needs were determined and priorities established. In this rural area a model for community action has been created.

EARLHAM CARE PROGRAM

Too often rural communities believe they cannot develop a range of services for older adults such as may be found in large urban centres. Earlham, Iowa has successfully disproven this.

A Typical Rural Community

Earlham is located 30 miles from the state capital of Des Moines. The town has a population of 800 persons and the surrounding school district an additional 2,000. Although served by excellent highways and located on the main line of the Rock Island Railroad, Earlham has no commercial bus, rail or air passenger transportation. There is no local hospital, but the resident doctor has hospital privileges in two hospitals in Des Moines and the 30-bed hospital at Dexter, a town 15 miles from Earlham.

Iowa has the largest proportion of persons aged 65 and over to its total population of any state in the United States of America. Madison County, in which Earlham is located, has the highest proportion of any county in the state. Between 15 and 17 per cent of the population of the town and the surrounding school district is aged 65 and over.

An Atypical Development

In 1961 when a group of Earlham citizens, calling itself the Earlham Community Development Committee, began meeting informally to discuss the town's future, no one could have predicted the dynamic happenings which would occur over the next few years. Among the many items discussed by the committee was the requirement for more services to meet the needs of older people. A special committee from the Ministerial Association was asked to explore the possibilities of constructing a nursing home.

In the latter part of 1962 when this special committee was ready to submit its recommendation that a 25-bed non-profit nursing home be built, the State Department of Welfare was asked for advisory help. This department suggested that the regional representative of the U.S. Office on Aging* be consulted. The consultations carried out in January 1963 resulted in a plan to conduct a survey in March 1963 to learn what services the elderly population needed and wanted.

Financial Support Approved

The survey was designed so that it served two useful purposes: it provided essential information; it initiated community education about various kinds of ancillary programs which could serve the older residents. The survey data were used in preparing a detailed proposal for submission to the State Department of Health requesting financial assistance for a demonstrational program. Allocations in the form of grants from the Division of Chronic Diseases of the Public Health Service of the U.S. Department of Health, Education, and Welfare were approved. The financial support was assured for three years, with the possibility this might be extended to five years. The Earlham Care Program was incorported and launched as of July 1, 1963.

Services Offered

Services offered by the Earlham Care Program include: visiting nurse, homemaker (now called home health aide), handyman, friendly visiting, telephone reassurance, counselling, transportation, employment and meals-on-wheels. Of these services, the three most used have been home health aide, handyman and

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* Now the Administration on Aging, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare.

transportation. An activity centre which allows for games, visiting, parties and other programs of interest to older adults has been established.

No Lag in Planning

The benefits to the aged and long-term ill residents of the community were well recognized by 1965. By mid-year planning to provide necessary financial support for the program when grant money would no longer be available had started. In addition, plans to extend the program to Dexter were under way. The expanded service commenced July 1, 1966. Meanwhile, the Department of Health of Iowa began encouraging the Earlham Care Program to broaden its services even further in order to cover all of Madison County. Approval was given to the provision of grants for an additional two years, that is, until June 30, 1968. On July 1, 1967 Madison County was included in the program, but to date only visiting nurse and home health aide services are offered. Certification in May 1967 of the Care Program as a Home Health Agency for Medicare greatly helped the users of services supported by this federal program in the United States.

Plans to finance the program when the grant through the State Department of Health is withdrawn appear to be well advanced. Medicare payments will, of course, continue. The legal right has been established whereby a tax for health needs may be levied if necessary. A contribution is anticipated from the Combined Fund (United Appeal). Other local support is also expected. It should be noted that up to June 30, 1967 the maximum expenditure for any one year reported by the program was just over $25,000.

Other Developments

Although the construction of a nursing home in Earlham was deferred in 1963 when it was decided that ancillary community services should be developed

first, the plan was not abandoned. A 29-bed non-profit nursing home was opened in early 1966. Four housing units for older citizens have been built by business men in the community through a loan from the Farm Home Administration. The monthly rent for a unit is $75. Development of additional accommodation of this kind is expected in the near future.

Unique Features

Aside from the importance of the various services which have amply proven their usefulness in helping older people remain part of the total community and outside institutional care, the Care Program has demonstrated three unique features. Earlham did not fall prey to the usual assumptions made by most small communities that it was too small and too poor to take positive steps to plan a total community program to serve the aged. Instead it went ahead with its plans and by so doing has created a model for community action. Expressed need for community services took precedence over the construction of an institution. Finally, a rural community has organized an integrated range of services to meet the needs of the aged — a range of services, established on a co-ordinated basis, often merely mentioned in large urban centres.

Growing Support

Basic community support was certainly evident when the Care Program was launched in 1963. As it "took hold" and grew, some of those who were the strongest objectors to its implementation became its strongest supporters and users. Recent surveys show that supporters now far outnumber the objectors. The local weekly newspaper has carried stories about the program and has added much to the continuing program in public education.

No Exclusive Right to Concept

Many communities both large and small look enviously at the achievements in Earlham. But Earlham is typical of hundreds of communities, except for one major and very important difference. Here community leaders were imaginative enough to conceive a broad plan of care for older persons, and the citizens supported the plan. Leadership, public education, and community support could bring about projects similar to that organized in Earlham in many rural and urban communities.

kundig center

Housing was identified as an urgent need of many members of the Kundig Center. Use was made of the old homes, owned by elderly home-owners, which surrounded the centre in the downtown area of Detroit. The centre itself took over responsibility for providing three meals on a daily basis. It became, in effect, the dining room and living room for many members, while not neglecting other older persons living in the community who required no help in living arrangements but needed other services. This imaginative development is described by its creators as a "campus program" for older persons.

KUNDIG CENTER*

The simplicity in the approach to solving the living arrangements for older people involved in the Kundig Center program has confounded many groups facing a similar problem. The program which has been developed demonstrates a rare ability to look at the daily evolving needs of older people, and imaginatively use both the immediately available resources to meet the needs in so far as possible, and devise additional ones required to fill the gaps. The result is described by its creators as a "campus program" for older persons.

History of Development

Started in 1954 as a day centre where older people could spend their hours of leisure with contemporaries over a card table and a cup of tea, the Kundig Center in downtown Detroit, Michigan has grown into a round-the-clock program. While in retrospect the sequence of the stages in the development seems but logical, it must be observed that, given identical or very similar circumstances in other areas, equal creativeness has not often been displayed.

The Kundig Center was originally located in a neighbourhood made up largely of big, old houses occupied by widows or older couples whose children had moved to the suburbs. Faced with the daily task of trying to help members of the centre find suitable living arrangements at a rent they could afford to pay, those responsible for the centre, notably the Very Reverend Monsignor W.F. Suedkamp, Secretary of Charities, Catholic Charities, Archdiocese of Detroit,

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* Ed. Note: The word "Center" is spelled as shown in the official name of the program. To conform to the spelling in the remainder of the document, the word is spelled "centre" in the narrative describing this program.

who originated the idea and has remained the inspiration of the campus concept of housing for older people, turned to the immediate neighbourhood to seek a possible solution. Investigation revealed that the elderly homeowners did not want to move out of their old surroundings; that they could use supplementary income to conserve their property; and that they would appreciate working with the social agency in locating suitable roomers for them.

The landladies were not interested in boarding the residents. The centre therefore employed a cook and the necessary kitchen staff to prepare three meals each day to be served in a central dining room. The design of "campus living" thus began to evolve with the objective: to meet all basic human needs as they are met on any university campus. Providing accommodation and the facilities for dining and activities in separate locations, instead of in one building, is in keeping with the sponsor's "out-of-doors and keep active" program. Residents are required to dress for dinner since it is believed this improves morale; they are required to walk to meals for the exercise it gives them.

Changes Over Time

Over the years changes have occurred. While use is still being made of some of the homes in the area, a 26-unit terrace financed through a direct loan program of the federal government was completed in 1962. Later private capital financed an additional 130 units. It should be noted that every unit has its own entrance, room and bath to provide each person with privacy. The need for companionship is essential if the older person is to remain mentally alert and in touch with reality. But everyone needs a place to which he can go to be alone. The Kundig Center does not believe that older people should be forced to share private living facilities. All meals continue to be served in the common dining room and

people ambulate to and fro. Approximate distance travelled is one-quarter to one full block. Cost of room and board is $90 per month, but residents reimburse the centre on the basis of ability to pay. About 150 persons participate in the living arrangements program at any one time; the average age is 77 years.

Aged in the Community Served

To complete the picture it should be noted that the Kundig Center serves older adults in the community who do not require any provision of living arrangements. A doctor and two nurses make weekly visits; a counselling service is provided; a staff member provides transportation to out-patient clinics but public transportation is readily available. For other problems such as lack of proper clothing, legal difficulties, and the need for someone to bury them in their chosen faith, old people can find a practical solution at the Kundig Center which caters to the needs of the aged regardless of race, colour, or creed.

Governing Council

Residents elect a council to govern the program. By this means they plan and organize their own activities, aided in their efforts through easy access to facilities available in the recreation area adjacent to the dining room and a wealth of community resources including theatres, parks, excursion boat, and an athletic field. They make suggestions regarding menus. To a certain extent they can participate in the general maintenance of the facilities and in the serving of meals. They care for their own rooms if able to do so; otherwise maid service is provided.

New Projects

Campus living programs were started in both Port Huron and Monroe, Michigan in 1966. The concept is equally applicable in large and small urban communities. It exemplifies dignified supervision while allowing the individual to maintain his independence.

little brothers of the poor

The Little Brothers of the Poor act as grandsons to 500 aged persons in Montreal. Race, colour or creed are of no concern; that an old person needs them is all that matters. To lonely older people, both rich and poor, these dedicated young men and their auxiliary helpers bring friendship, love and, when required, the necessities of life to their "adopted grand-parents".

LITTLE BROTHERS OF THE POOR

Old people are the central focus, the interest, indeed the whole reason for the existence of the Little Brothers of the Poor. In 1946 a young Frenchman in Paris, seeing the loneliness, poverty, misery, and infirmities of the old people who had survived World War II, dedicated his life to God through serving the aged poor. Believing this service could best be carried out by young men living among the poor in their own communities, he established his base of operations in a tenement neighbourhood in Paris. Young men with ideals for service to the aged were attracted to become little brothers. Over the years houses were established in other centres in France, as well as in Morocco, the United States of America, and in July 1962 in Montreal.

The Lonely Aged

That "poverty" is not defined solely in terms of economic need by the little brothers becomes quickly apparent as the story of their service unfolds. The 500 elderly folk in Montreal visited regularly by the little brothers or their auxiliary helpers are not necessarily in need of monetary assistance. All, however, are lonely — perhaps they have no relatives or close friends, perhaps they are separated from loved ones by distance, perhaps they have simply been "forgotten". The little brothers assume the role of grandsons with all that this implies as to love, compassion, and help when needed. The little brothers' mission is to bring friendship and love as well as the necessities of life to their "adopted grandparents".

The Little Brothers in Montreal

In Montreal the Little Brothers of the Poor are located at 2112 Bleury Street. An old house

serves as both headquarters for their operations and their home. There is certainly no evidence of material luxury; yet there is a luxurious warmth in the welcome extended to the visitor.

Three little brothers serve in Montreal and live in the house on Bleury Street. A resident priest completes the regular "family", but 12 young men — some married, some single — serve as auxiliary workers; some are students; some young businessmen. In 1967 six young girls who were 17 and 18 years of age joined the auxiliary service. The volunteers, both men and women, working one to two hours weekly, each make one or two visits during this time.

Visits to the Aged

Those who suffer from great loneliness are visited every two weeks. Others are visited monthly or more often in the event of emergency. While flowers play an important part in the gifts the little brothers always take to their "grandparents" to demonstrate their love, for some, gifts of food must take precedence. But on birthdays, the "grandmothers" always receive flowers; the "grandfathers", wine and cake.

Summer Camp

A camp is operated for three months every summer — the Chateau of Happiness at Lac Laroche. About 60 elderly persons spend one month at the camp. Here couples share rooms, but the majority going to the chateau are single persons and each has his (or her) own room. Three little brothers, men from the auxiliary service, and members of various religious orders staff the camp. The campers, if physically able, care for their own rooms. Those who cannot do so, and those who require some personal care, are served by the little brothers. Although there is a waiting list for the camp, a camper, once accepted,

can return each year as long as he wishes and is able to do so. For some, this is a new experience of a family life; for others, a renewal of family life practices.

Christmas Party

The annual Christmas party is the high point of the year's activities. It is attended by 2,000 old people. This event represents a special effort to reach, not just the regular "grandparents", but all those who may feel particularly lonely at this family festival season.

Source of Funds

Although the little brothers dedicate themselves to poverty, the services provided to the aged require money. The hope is that through campaigns for funds, special donations, and special events such as bazaars, it will in time become self-supporting. Meanwhile, about two-thirds of the budget comes from the mother house in Paris.

Service Brings Rewards

Men who wish to become little brothers are indeed young men for they must be between the ages of 18 and 30. They must have a desire to dedicate themselves to the service of the aged. Although they must be Roman Catholic, the little brothers serve the aged of all religious communions. For a little brother, the only question is whether or not an old person needs him — race or language is of no concern. As an example, in Chicago about 75 per cent of the "grandparents" are Negroes. While the aim is to provide food to relieve hunger, smiles to replace tears, and kindness instead of neglect, the little brothers recognize full well that they themselves receive much from their "grandparents". Mr. Jean-Claude Guérin, the Director in Montreal, sums it up: "We have 500 to whom we can give, and we receive from 500."

second careers in voluntary service

Believing that there are older retired persons who have both qualifications for, and interests in, voluntary service and that there are agencies that can use such volunteers, the National Council of Jewish Women has introduced a pilot project in Toronto known as Second Careers in Voluntary Service. When an application is received, an interview is arranged. Volunteers must agree to accept some orientation and training for the work to be undertaken. Further, volunteers must be willing to offer service regularly.

SECOND CAREERS IN VOLUNTARY SERVICE

A second career implies undertaking some new field of endeavour. Even in later life there are those who embark upon employment very different in nature from that followed in their earlier years. For many, monetary reward is of major importance, either because of financial need, or because of the psychological satisfactions of remaining in the "working world", as society generally defines the term. But while there is no denying that many older people require additional financial resources, there are those, even those in financial want, who have deeper needs — the need to be needed; to do something worth while; to enjoy the experience of warmth, understanding and companionship.

Toronto Project

Sensitivity to these deeper needs was a determining factor in influencing the National Council of Jewish Women of Canada to introduce a pilot project, under the guidance of a Second Careers Committee, to help retired persons undertake second careers in voluntary service. In addition, a survey in Toronto had shown that community agencies (educational, civic, health and welfare) were understaffed and could use the skills and experience older persons have to offer but which are not being used. Over 30 agencies in the Metropolitan Toronto area agreed to accept volunteers. A community-wide recruitment campaign was launched to tell the story of possible second careers. Industries, church clubs, professional organizations, labour unions, as well as the communications media were involved.

A special Volunteer Bureau was established to accept applications and arrange interviews with interested individuals. Any man or woman of retirement age may apply regardless of race, colour or creed. Applicants are placed according to their

qualifications and interests and the current needs of the agencies. Volunteers must, however, be willing to offer service regularly and agree to accept some orientation and training for the work to be undertaken. While the agency involved does the necessary training, a close contact is maintained with the Second Careers Committee to ensure satisfaction of all concerned in the placement of the volunteer.

National Council of Jewish Women Will Help

Patterned after a program known as the Senior Volunteer Corps being pioneered in cities throughout the United States of America by the National Council of Jewish Women of that country, the venture, begun in Toronto in October 1966, is the first of its kind in Canada. It is hoped that as the demonstrational project provides experience to those engaged in its development, more programs will be started in other parts of Canada. While the National Council of Jewish Women of Canada is willing and eager to provide guidance to its own local units in establishing more projects for second careers in voluntary service, the officers of the national council are equally willing to share their experience and to help other groups in organizing such a program either with or without the direct involvement of the council's member units. They underline the need for, and potential of, such programs. Their objective evaluation of the pilot project makes them quite conscious of the fact that sponsorship of the project, and therefore the association of the National Council of Jewish Women's name with publicity, may have been a hindrance to recruitment in some cases. Some non-Jewish adults thought that the program was solely for older Jewish persons who wished to volunteer.

Some Problems

Those engaged in developing the project have encountered problems. One thing they have learned is

that rapid development does not occur overnight. Often older people have shown a keen interest in undertaking some service, but when the actual moment of commitment came they have withdrawn for fear they might not succeed in the assignment. In some cases a language barrier has prevented participation. Some potential volunteers found that transportation costs to and from the agency prohibited them from serving. Ways and means to solve this problem are under review. More interpretation of the program is needed, not just to those who have retired, but also to persons coming into retirement. Employers and labour unions can be expected to help in the interpretation to at least those entering retirement. Where pre-retirement preparation programs have been organized within a business or industry, access to those coming into retirement should be relatively easy.

Examples of Voluntary Service

Opportunities for second carres in voluntary service can be found in many agencies including libraries, hospitals, homes for the aged, nursing homes, blood donor clinics, educational institutions, recreation centres and family service bureaux. Examples of services being performed by volunteers in the Toronto project may help to illustrate. A former Hebrew teacher who did woodworking as a hobby teaches in the woodwork shop in the school operated by the Ontario Society for Crippled Children; a retired factory worker, always an able swimmer, now serves as a volunteer in the swimming activities at the Boys' Village, a residential home for disturbed boys; a former business man serves as a driver for a meal-on-wheels program; and several persons, who are themselves handicapped and partially homebound, carry out telephoning assignments, at times most convenient to them, for the Red Cross Society, including the Blood Donor Clinic.

Wider Possibilities

Any community could organize a second careers in voluntary service project; indeed older people could organize one themselves.

valleyview hospital

A hospital where only aged persons receive care, treatment and rehabilitation when suffering from psychiatric illness associated with aging is certainly not common. The program being developed at Valleyview Hospital, Essondale, British Columbia is demonstrating that the capacity of older adults to respond to treatment is much greater than has been generally assumed.

VALLEYVIEW HOSPITAL

It is very unusual to find a mental health facility devoted solely to the care, treatment and rehabilitation of older adults suffering from mental, emotional, or behavioural disturbances associated with aging, and admitting them directly to its wards. Such is the case at Valleyview Hospital, Essondale, British Columbia.

Historical Development

Valleyview Hospital emerged as a separate entity with its own administration and staff in May 1959. Prior to this it had been operated as an annex to the Provincial Mental Hospital (Riverview Hospital) and was called a Home for the Aged. Changes were carried out in stages. With the repeal of the Provincial Home for the Aged Act in January 1960, Valleyview became an operating unit under the Mental Hospitals Act. Aged mentally ill persons could now be admitted directly to Valleyview, instead of via Riverview Hospital. Passage of the Mental Health Act in 1964 established Valleyview Hospital as a mental health facility for the care and treatment of aged persons suffering from phychiatric illness associated with aging — a provincial mental hospital to serve aged persons only. To be eligible for admission, a patient must be aged 70 or over and a qualified resident of the Province of British Columbia.

Hospital Facility

The hospital site is on a hillside overlooking the Coquitlam and Fraser Rivers. There are 15 wards with a rated capacity of 791 beds. Admitting and infirmary areas are located in a large modern building, while three other buildings and three cottages, all adjacent to the main building, house the continuing treatment wards.

Concepts

The hospital's program is based on the belief that the capacity of older persons to respond to treatment is much greater than previously assumed. Further, there is close adherence to the belief that older persons should remain in the community, preferably in their own homes, in so far as possible. When, however, hospital care becomes necessary, it should be considered as a phase in the course of their illness and not as a "terminal disposal". Both patient and relatives should be made to feel that hospital care may be only temporary, and that if and when he improves sufficiently, he will be returned to the community. Thus rehabilitation begins with admission to the hospital. Every effort is made to cure disease and correct defects. Each patient is encouraged to engage in the maximum physical activity of which he is capable. Realistic goals are established for him to strive towards.

Admissions and Discharges

When patients come into hospital, they are assigned to the admitting wards for assessment. Those who show a good response to treatment are quickly transferred to open integrated (male and female) rehabilitation units to be prepared for discharge. Patients who are physically disabled and respond less quickly to treatment are placed in the infirmary wards. Their hospital stay will be longer. When poor response to treatment is evident, transfer is to the continuing treatment units; there are fewer discharges.

The development of an active treatment and rehabilitation program, specially designed for aged persons, has multiplied demands for admission and increased discharges. The following figures show the picture for admission:

April 1, 1963 - March 31, 1964 - 28 applications per month;
April 1, 1964 - March 31, 1965 - 33 applications per month;
April 1, 1965 - March 31, 1966 - 41 applications per month;
April 1, 1966 - March 31, 1967 - 63 applications per month.

On the other hand, during the period April 1, 1965 to March 31, 1966, of approximately 500 admitted to hospital (mostly over the age of 70 years), 200 were returned to the community. In late 1967, there were 176 persons in hospital who could have been discharged to other types of institutional care if beds had been available. Thus, as is so often the case, the lack of ancillary community facilities blocks active treatment and rehabilitation programs from serving the greatest number of patients of which they are capable because beds are occupied by patients who should be discharged, but there is no place for them to go.

While discussing discharges, it is appropriate to review where the patients previously referred to went. Almost one-third returned to their own homes or went to live with friends or relatives or some other private arrangement; one-third were placed in boarding homes; one-third, because of physical impairment, went to nursing homes or private hospitals (a term used in British Columbia in relation to proprietary nursing homes). Financially, almost 92 per cent of those who returned to their own homes or other private arrangements were able to meet their own costs. Eighty-three per cent of those who went to boarding homes were able to finance the costs of care; 64 per cent of those who went to nursing homes or private hospitals had adequate means to meet even the high costs involved in these institutions. In the case of the latter group, if a prolonged stay in the institution is required, some may require public financial support at a later date.

There are two other geriatric units within the Mental Health Services — Dellview Hospital at Vernon, which has a fair number of direct admissions

from the community, and Skeenaview Hospital (all male) at Terrace, which serves primarily for long-term continuing care. To assist in keeping active treatment beds available at Valleyview Hospital, patients requiring long-term care may be transferred to one of the other geriatric units.

Staff

Generally speaking, the staff serves only the patients at Valleyview Hospital. This includes administrative, medical, nursing, physiotherapy, chaplain (Roman Catholic and Protestant), social service, housekeeping, and kitchen staff as well as a trained beautician. A radiologist from Vancouver visits the hospital. Pathology services are shared by the other mental health facilities of the Essondale complex. The resident surgeon and visiting surgeons from the Crease Clinic (part of the Riverview Hospital) are on call as needed. Dental and podiatry services are shared with Riverview Hospital. A barber also serves the two hospitals. The doctors from Valleyview and Riverview Hospitals rotate on night call and serve both facilities.

Educational and Consultative Programs

During a two-year course in psychiatric nursing offered at the Education Centre (School of Nursing) at Essondale, 30 to 40 of the nursing students at a time are assigned to Valleyview Hospital in order to gain psychiatric knowledge and experience in a geriatric setting. Persons employed as psychiatric nursing aides are rotated through a one-week training program provided by the Education Centre as soon as possible following their employment. Further supervised experience, under the direction of an instructor from the centre, is then arranged on the wards. In June 1967, a psychiatric consultation service was made available by the

medical staff of the hospital to physicians in the New Westminster-Fraser Valley area. At an early date it is expected that a similar arrangement will be available in the Burnaby-Vancouver area. Members of the staff have periodically addressed meetings of the operators of boarding homes, nursing homes, and related facilities in Vancouver.

The visitor to Valleyview Hospital cannot fail to be impressed by the concern for older people demonstrated and expressed by the staff. The belief that public education is needed in helping prevent, or at least reduce, some of the stresses which lead to break-down in the mental health of older persons is inherent in the program being developed. Included also is interpretation of the role of an active treatment and rehabilitation program to meet the needs of older persons suffering from mental illness resulting from the aging process.

Some Important Practices

Certain practices evident in the hospital's program exemplify the helping relationships being fostered. For example, patients are admitted by appointment with only two, or at the most, three admissions per day (except in the case of emergency). This allows time for the staff, the patient, and the family to gain confidence as a team, all working towards the best interests of the patient. It is through the early encounters that the greatest gains often accrue. The involvement of patients when they are assigned to an integrated rehabilitation unit in undertaking light housekeeping duties, setting tables in the dining room, and serving meals, assists in preparing them for discharge to the community. Fishing trips, outings to Victoria and other points, also help to renew competency in living in the outside world.

Staff from the Social Service Department provide casework services on a pre- and post-admission

and pre- and post-discharge basis. Further, Dr. John Walsh, Medical Superintendent of the hospital, visits patients following discharge as frequently as possible in order to maintain contact with them.

Professional staff members function as a team. All possible information is made available as quickly as feasible to each. It is emphasized that the free flow of information must not be hindered by poor communication or restrictive attitudes. Every effort is made to instill in non-professional staff members the philosophy and goals of the program. Thus the total staff shares the feeling of belonging, and contributes both inside and outside the hospital in furthering its aims.

Principles in Practice

Embodied in the philosophy underlying the development of Valleyview Hospital are three principles:

1. Sympathy, kindness and companionship must be fostered;
2. Aged persons must be treated with respect and accorded the dignity due to their experience;
3. Older adults must be assured that their problems will be attended to.

The staff and all those associated with the program are devoting their efforts to putting these principles into practice.

epilogue

EPILOGUE

Society must learn to involve its older members so that they may continue to have opportunities for self-expression, intellectual stimulation, service to others, joy in living. This goal presents a challenge. Success will depend upon our willingness to allow older adults to participate in the planning, organization and implementation of programs which are to serve the aged and in which the aged can and should serve.

The projects described in this publication are demonstrating new approaches. Some are allowing for the continuing active engagement of older people; others are assisting those who are no longer able to assume an active role on their own behalf or who need some supportive help to do so. All are imaginative; all are unique in that rarely, if ever, does it appear that they have been organized elsewhere. It should not be construed, however, that the projects which have been included are the only ones that offer new and challenging approaches. There are others, for example:

(a) a program in which services are offered by aged persons to aged persons;

(b) a co-operative housing development where, in effect, older people are "looking after" younger people; not to mention the fact they are so organizing themselves that, barring the need for acute hospital care, aged tenants may remain in their own apartments for the rest of their lives;

(c) a group of senior citizens bringing new and different services to an elementary school;

(d) a state training school for retarded children where older folk serve as foster grandparents to children whose mental age is no more than five years, although chronological age may be as high as eighteen years.

For the reader's information, a brief statement about each of these programs follows.

In 1963, the volunteer visiting program, operating at the Henry Street Settlement, located on the Lower East Side of New York City, was expanded in co-operation with three other community organizations. A three-year demonstrational program was organized. Called "Services for the Elderly by the Elderly", the development that occurred is a "story of giving of oneself; a story of people helping people, of community agencies striving to work together for the benefit of the older adults living in the community".

The volunteers served basically the same kind of people as themselves — the elderly poor. Besides friendly visiting to homebound and hospitalized persons, volunteers undertook shopping, cooking, and some light housekeeping duties for recipients; they provided escort service to clinics and hospitals, paid bills and had prescriptions filled. They prepared and served coffee in the lounge for patients and staff at a clinic. They assisted trained personnel in the Pharmacy of the same clinic in certain routine tasks.

Visitors were often not in good health themselves, but having "something to do" for others kept them active; meanwhile, some of the recipients were helped to become self-sufficient — a few even became volunteers themselves. The program proved to be an important factor in integrating three ethnic groups — Jewish, Spanish, and to some extent Negro. This dynamic development not only helped to meet the needs of older adults, it "utilized them and their strengths whenever possible".

Morningside Gardens is a middle-income co-operative housing project with about 1,000 apartments located in the Manhattan area of New York City.

Between 500 and 600 adults aged 60 and over live in the development which serves all ages. But the older adults make up four-fifths of the management-tenant policy making group for the project. Thus older people are really "looking after" younger people.

Within this project, Morningside Gardens Retirement and Health Services have been organized in co-operation with St. Luke's Hospital. An Operational Committee, composed of older tenants, concerns itself with day-to-day developments. Services include: provision of information about resources in the community which help older people; services of a public health nursing consultant; counselling ranging from that of a personal nature to counselling on health insurance, wills, estates, retirement planning and so on; friendly visiting services and telephone reassurance services; arranging health education programs, social, cultural and recreation activities and other programs of a like nature; organizing the tenants of Morningside Gardens to deal with problems of concern to older adults; recruiting volunteers to help people living in Morningside Gardens and to work on community problems; arranging the handling of medical emergencies and hospital admissions. The entire Morningside Gardens development is a vital demonstration of the involvement of older people in the policy making, planning and organizing of a project.

In 1962, the Council Center for Senior Citizens* in Brooklyn, New York demonstrated that older adults can provide service in a public (elementary) school. Other centres have since followed this lead, for example, some in Detroit, Michigan.

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* Ed. Note: The word "Center" is spelled as shown in the official name of the program. To conform to the spelling in the remainder of the document, the word is spelled "centre" in the narrative describing this program.

In the Brooklyn program, the senior citizens were introduced to the students at a "Gay Nineties Revue" — a program of music and dancing performed by the centre's entertainment group for the entire student body. The tremendous success of this introduction was quickly matched in the daily programs in the school, with the volunteers working under the supervision of the teaching staff. One man gave four to five hours every Tuesday morning in maintaining and repairing school library books and in helping to keep the stacks in good order. Another senior volunteer helped in the publishing of a children's school newspaper, typing copy and cutting stencils. A retired carpenter assisted the shop teacher for three hours once every week, repaired school equipment, and constructed class library bookcases. The Gardening Club of the centre gave plants to the kindergarten class at holiday times. A concert pianist gave recitals at school assemblies. Involvement of two older adults in a sixth grade class, where they told of their experiences when they immigrated to the country at the turn of the century, resulted in an invitation from the school's social studies teaching staff that the older "experts" visit their classrooms to recount their experiences on such topics as: citizenship; life without movies, radio and TV; the suffragette movement; life in Europe and America in the early twentieth century; and early development of the labour unions.

Following the initial experience in the one school, the Brooklyn School Board invited members from the Council Center for Senior Citizens to serve in summer school classes organized in a number of schools for so-called socially disadvantaged children 10 to 12 years of age. The older volunteers, under the supervision of the teachers, served in the libraries helping children find suitable reading material, and in the classrooms helping children with their reading. When summer classes concluded, some older volunteers continued to serve in the pre-kindergarten classes.

The importance of older people to the community through their participation in programs which serve the community has been amply demonstrated through these school programs. Equally well demonstrated has been the fact that young people need the older adult as much as the older adult needs the young. We are therefore further reminded that if we fail in our responsibility to keep, or where necessary bring back, older people into the mainstream of community life, our children will not have the opportunity to profit from their years of living; many of them will never experience the warmth of an association with a "grandparent".

The Foster Grandparent Program, organized at the State Training School, American Fork, Utah is one of many such programs established in the United States of America — some serve neglected infants and young children; others serve emotionally disturbed, physically handicapped or retarded children, and so on. Reports about the various programs may sound too good to be true. A visit to a program convinces one that they are not exaggerated.

The program at American Fork was one of the first 22 organized in the United States. All are administered by the Administration on Aging, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare under contract to the Office of Economic Opportunity. Through employment of older workers an effort is being made to enrich the lives of children in institutional care. The minimum age for foster grandparents is 60 years, but in Utah people 75 years of age were serving, and some programs are reporting foster grandparents of even more advanced years. Health of foster grandparents showed improvement. Increased income proved a blessing and allowed some of the older participants to improve their living arrangements. But the satisfactions of once again being needed, of filling a meaningful role in society, of having recognition and status —

these are the benefits attested to by all the foster grandparents in commenting upon the program. The children benefitted too. Some who had never dressed themselves, fed themselves, or talked, dramatically demonstrated the results of the program in Utah when they performed at an assembly attended by parents, friends, and the staff of the training school.

Similar "miracles" are being reported by other foster grandparent programs. Their impact in serving the community's handicapped, serving in institutions where staff shortages are often acute, and serving to bring some pleasure to children in a world which up until recently has been passing them by, cannot be denied.

It is encouraging to observe the inventiveness being displayed in some places by some groups in using the time and talents of the older members of society. It is equally encouraging to find more and more older adults in Canada asking: "What can we do to help ourselves, each other, and the community?" Those who are serious in asking this question are actively engaged in trying to find some of the answers.

appendix

APPENDIX

Further information concerning projects described in this report should be obtained directly from the agency.

Name and Address of Projects or Sponsors

1. Care Services, Departments of Health and of Welfare, 114 Garry Street, Winnipeg 1, Manitoba, Canada.
2. Council Center for Senior Citizens, 1207 Kings Highway, Brooklyn, N.Y. 11229, U.S.A.
3. Earlham Care Program, Earlham, Iowa 50072, U.S.A.
4. Family Service Association of Montreal, 4515 St. Catherine Street West, Montreal 6, Quebec, Canada.
5. Henry Street Settlement, 265 Henry Street, New York, N.Y. 10002, U.S.A.
6. Little Brothers of the Poor, 2112 Bleury Street, Montreal 2, Quebec, Canada.
7. Morningside Gardens Retirement and Health Services, Apt. MF, 100 La Salle Street, New York, N.Y. 10027, U.S.A.
8. National Council of Jewish Women of Canada, 4700 Bathurst Street, Willowdale, Ontario, Canada.
9. Saskatchewan Council for Crippled Children and Adults, 1410 Kilburn Avenue, Saskatoon, Saskatchewan, Canada.
10. Social Services for the Aged, Catholic Charities, Archdiocese of Detroit, 9851 Hamilton Avenue, Detroit 2, Michigan, U.S.A.
11. Utah State Council on Aging, 140 State Capitol, Salt Lake City, Utah 84114, U.S.A.
12. Valleyview Hospital, Mental Health Services Branch, Department of Health Services and Hospital Insurance, Essondale, British Columbia, Canada.

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